Diabetes Mellitus Interagency Coordinating Committee (DMICC) Meeting
Federal Implementation of the Diabetes Quality Improvement Project (DQIP)
January 14, 2000
8:30 a.m.–4:00 p.m.
Holiday Inn—Bethesda
Bethesda, Maryland

Participants:

Patricia Bryant, PhD	National Institute of Dental and Craniofacial Research
Joan Chamberlain	National Institute of Diabetes and Digestive and Kidney Diseases
Yen-pin Chiang, PhD	Agency for Healthcare Research and Quality
Richard Eastman, MD	National Institute of Diabetes and Digestive and Kidney Diseases
Michael Engelgau, MD, MS	Centers for Disease Control and Prevention
Valerie Gamache, MBA	HealthCare Horizons, Inc.
Sanford Garfield, PhD	National Institute of Diabetes and Digestive and Kidney Diseases
N. Krish Krishnan, PhD	Center for Scientific Review
Louis Emmet Mahoney, MD, DrPH	Center for Quality Health Resources and Services Administration
Philip Sheridan, MD	National Institute of Neurological Disorders and Stroke
Elizabeth Warren Boulton, RN, MSN	Hager Sharp

Speakers:

Kelly Acton, MD, MPH	Indian Health Services
John Eisenberg, MD	Agency for Healthcare Research and Quality
Barbara Fleming, MD, PhD	Health Care Financing Administration
Sheldon Greenfield, MD	New England Medical Center
Roland Hiss, MD	University of Michigan Medical School
Richard Kahn, PhD	American Diabetes Association
Leonard Pogach, MD, MBA	Department of Veterans Affairs
Frances Stewart, MD	Department of Defense
Dorothy Tucker, MBA, MSW, MA	National Committee for Quality Assurance

Welcome and Introductions

Richard Eastman, MD, Chairman, Diabetes Mellitus Interagency Coordinating Committee (DMICC), and Director, Division of Diabetes, Endocrinology, and Metabolic Diseases, National Institute of Diabetes and Digestive and Kidney Diseases (NIDDK), National Institutes of Health (NIH), welcomed all in attendance. He noted that Dr. Nancy Miller from the NIH Office of the Director and Dr. Allen Spiegel, the newly appointed NIDDK Director, were unable to attend the meeting.

Overview of the Meeting

Barbara Fleming, MD, PhD, Senior Clinical Advisor, Health Care Financing Administration (HCFA), provided a brief history of the Diabetes Quality Improvement Project (DQIP), which has developed into a collaborative effort to improve the care of diabetes and the quality of life for patients with diabetes. DQIP's initial goals in striving to improve care include the development of a single set of comprehensive performance measures for diabetes from which national standards could be identified, the ability to compare standards of care across multiple health settings, and the identification of best practices that then could be disseminated throughout the health care community.

The three key points to understanding DQIP are that the DQIP measures (1) are not guidelines but rather performance measures that serve as indicators to assess care and provide a strategy for accountability, (2) have more rigorous criteria than do guidelines, and (3) are in wide use in a variety of health care plans and settings. Approximately 400 managed care plans in the commercial and Medicare markets will be collecting and publicly reporting DQIP measures data in the year 2000. In addition, HCFA is collecting data on three of the DQIP measures in fee-for-service plans that have contracted with Medicare for all beneficiaries in all 50 states.

In 1997, HCFA assembled a core group of producers and users of diabetes performance measures and provided funding for DQIP. The DQIP Steering Committee included HCFA, the Department of Veterans Affairs (DVA), the American Diabetes Association (ADA), the American College of Physicians (ACP), the American Academy of Family Physicians (AAFP), the Foundation for Accountability, and the National Committee for Quality Assurance (NCQA). The Steering Committee selected 15 experts in diabetes and measure methodology who, under the leadership of Dr. Sheldon Greenfield of the New England Medical Center, produced the DQIP measures for diabetes care for patients aged 18 to 75 years. These measures, developed using three major criteria—evidence to support the measure; ability to collect the measures feasibly, accurately, and reliably; and existing variability among physicians and practices in performance of the measures—include

1. Hemoglobin A1c (HbA1c) tested
2. Poor control (HbA1c>9.5)
3. Eye exam performed
4. Lipid profile performed
5. Lipids controlled (LDL <130 mg/dL)

6. Kidney status monitored
7. Blood pressure controlled
8. Foot exam performed

More than 200 individuals or groups provided comments on this set of eight measures, which were released in August 1998. Dr. Fleming re-emphasized that the performance measures developed by the DQIP panel are just that—measures, not guidelines. They are based on both the state of evidence and the state of practice. DQIP provides a conceptual framework for the development of future measurement systems both in its approach to content and partnerships. The existence of a single set of broadly accepted performance measures allows for valid comparison of diabetes care across diverse health care settings for the first time for any disease. This strategy provides opportunities for meaningful benchmarking and accountability and enhanced quality improvement (QI) while simultaneously reducing burdens on physicians and providers. Growing interest in DQIP has led to the expansion of the initial DQIP partnership base, which now includes several Federal and private sector partners. Dr. Fleming noted that Health and Human Services (HHS) Secretary Dr. Donna Shalala has asked Federal agencies to commit to these measures and implement ways to collaborate on DQIP as Federal agencies. The current meeting is part of that commitment.

Six of the eight measures have been incorporated into Health Plan Employer Data and Information Set (HEDIS) 2000 and will be reported publicly for Medicare, Medicaid, and commercial plans during 2000. HCFA is using claims data to generate three measures that can be obtained for all beneficiaries in the fee-for-service setting. A variety of other organizations and agencies also are using the DQIP measures. In addition, HCFA, the ADA, and the American Association of Health Plans have developed extensive materials in support of DQIP, including standardized software and paper collection tools, a data analysis package, training materials, and QI tools.

Results of the New York State PRO Pilot Study, which is examining the performance of measures in different health care settings, found that an average of 37 percent of diabetics had their blood pressure under control, 42 percent received foot exams, 41 percent received eye exams, and 34 percent were monitored regularly for nephropathological changes. The overall results of this pilot study indicate that there are many opportunities for improvement in delivery and receipt of care and that care varies considerably across HMOs and fee-for-service vendors. The Minnesota PRO, which covers older Medicaid patients in eight plans within the state, also is monitoring DQIP measures. One interesting finding was that a relatively high proportion of diabetics (mean of 72 percent) received an A1c test during the reporting period. However, data also show that approximately 39 percent of diabetics tested had an A1c level greater than 9.5.

DQIP is an ongoing process that will continue to evolve and develop as changes and advances in evidence and practice occur. Data collected thus far show room for improvement in all measures. HCFA is funding DQIP 2.0, which includes a re-evaluation of the current DQIP measure set that will accommodate changes based on new, compelling data and the state of practice for diabetes care.

DQIP—A Translation of Research into Practice

John Eisenberg, MD, Director, Agency for Healthcare Research and Quality (AHRQ, formerly the Agency for Health Care Policy and Research/AHCPR), and Operating Chair, Quality Interagency Coordination (QuIC) Task Force, opened his presentation by recognizing that historically there have been few standardized, validated performance measures for diabetes. However, DQIP has helped to address this gap by using a "bench to benchmarking" approach in developing a set of standards for practice. The DQIP program represents the translation of research into practice. Biomedical research and clinical trials sponsored by NIH led to outcomes and effectiveness research sponsored by AHCPR, including the Diabetes Patient Outcome Research Team (PORT) at New England Medical Center. These studies documented the relationship between process of care and outcomes in diabetes, and they led to the design of performance measures that were tested by HCFA's PRO program.

As stewards of public money, HCFA and other Federal agencies are using DQIP to bring together and establish new partnerships to amplify the program's message and as leverage to move the health care system and, thus, patient care forward. The various Federal agencies involved in DQIP have different roles in this and other health care efforts. The Federal Government plays many roles in health care quality that are exemplified by DQIP—conducting and sponsoring basic and clinical research (e.g., NIH), sponsoring and conducting health services research (AHRQ), delivering services (e.g., DVA), purchasing services (e.g., HCFA, Office of Personnel Management, Indian Health Service [IHS]), regulation (Food and Drug Administration [FDA]), and surveillance and public health (Centers for Disease Control and Prevention [CDC]). DQIP provides a mechanism to bring together these activities not only within the Federal system but also across the private sector.

The QuIC was established by President Clinton to enable Federal agencies with health care responsibilities to coordinate their activities to

- Measure and improve quality of patient care
- Provide beneficiaries with information to assist in making choices regarding care
- Develop the infrastructure needed to improve the health care system

QuIC participants include DVA, Department of Defense (DoD), several divisions of HHS, the Department of Labor (which regulates OSHA and ERISA), OPM, the Office of Management and Budget (OBM), the Coast Guard, the Federal Bureau of Prisons, the Federal Trade Commission, the Commerce Department, and the National Highway Transportation and Safety Board (NHTSB). Interagency coordination is expected to assist in identifying and implementing evidence-based, validated performance measures, including measures for diabetes care, and eliminating redundancy and overlap across agencies. To that end, the QuIC Task Force has focused on efforts to improve quality care among patients, emphasizing performance practice measures in the following areas:

- Diabetes care (QuIC's first major project for interagency collaboration)
  - Evaluation of common guidelines for care between DVA and DoD

- Conferences to identify successful strategies
- Agreement among Federal agencies to collect, compare, and report the performance of providers with respect to DQIP measures

♦ Depression diagnosis and care
♦ Reduction in medical errors
♦ Evaluation of the effects of working conditions on quality of care provided by health care workers

The QuIC Task Force will continue to take steps to demonstrate how DQIP improves patient care and quality of care.

DQIP—A History and the Measures

Sheldon Greenfield, MD, Professor of Medicine, Tufts University School of Medicine, New England Medical Center, provided a "case study" of DQIP as a collaborative effort—involving HCFA, ADA, AAFP, DVA, CDC, NCQA, and ACP—to develop a comprehensive set of measures for diabetes. He emphasized the importance of gathering data and support for DQIP before the project was formally launched by multiple agencies and the private sector. He cited Drs. Eastman, Fleming, and Kahn as instrumental in this effort.

The primary features of DQIP measures were outlined by Dr. Greenfield. As he explained, the measures and DQIP itself

- Are comprehensive and cover all aspects of diabetes and diabetes care
- Emphasize both process and outcome and strive to identify the optimum process to achieve the best patient outcomes
- Identify risk according to case mix and subgroups, based on both frequency of a measure within a certain population and threshold variation
- Address accountability (i.e., for what can physicians fairly be held responsible) and improvement (i.e., seek continuous improvement in patient care and status by setting goals higher)
- Are "politically" sensitive within the context of diverse clinical setting, practices, and health care delivery systems

DQIP measures may be used as potential predictors, or as a gradient, of risk for adverse conditions associated with diabetes. Following this general background, Dr. Greenfield provided data and applications of several of the eight DQIP measures. For example, for the HbA1c test, which indicates glycemic control, providers are expected to report the percentage of patients receiving at least one test during the reporting year, the percentage of patients whose most recent HbA1c level is greater than 9.5 percent, and the mean and distribution of patients with HbA1c levels in five categories (<7.0 percent, 7.0–7.9 percent, 8.0–8.9 percent, 9.0–9.9 percent, >10 percent). The first two reporting values allow for accountability, whereas the third serves as a mechanism to track internal QI.
Another DQIP measure involves tracking the percentage of patients receiving an eye exam (as a proxy for a dilated eye exam) by an eye care professional (i.e., optometrist or ophthalmologist) in

the reporting year, or in the year prior to the reporting year if the patient meets two of the following criteria: is not taking insulin, has an HbA1c less than 8.0 percent, and/or had no evidence of retinopathy in the previous year. Implementing this measure should improve patient outcome and provider accountability as well.

Monitoring serum lipids involves collecting information on the percentage of patients receiving a lipid profile test during the reporting year or prior year and the percentage of low-risk patients whose most recent LDL is less than 130 mg/dL; these measures allow for accountability.

Urine proteins are used to monitor diabetic nephropathy based on either the microalbuminuria test or medical recognition of nephropathy, which requires certain criteria to be met. These measures are designed to promote accountability among providers.

The DQIP accountability measure for blood pressure involves tracking the percentage of patients whose most recent blood pressure reading is <140/90.

Tracking foot care and foot examinations remains a challenge in large part because such aspects of care of diabetic patients are not documented regularly by doctors in patients' charts. In addition, controlled studies of foot care in diabetics are absent. A patient survey is being field tested to evaluate the DQIP measure of a regular foot examination.

In summary, eight DQIP measures were finalized in 1998; the complement of patient-derived measures is expected to be finalized in 2000. These measures may be revised, and other measures (e.g., immunizations, education, functional status, satisfaction) may be added over time, pending new evidence and/or improved practices. The current DQIP measures are comprehensive and continued success and improved quality will require collaborations among agencies and between the public and private sectors.

DQIP and the Private Sector (Part 1)

Richard Kahn, PhD, Chief Scientific and Medical Officer, ADA, highlighted the ADA's Recognition Programs, which have served as vehicles for the development and implementation of standards of care and measures for diabetes care. In the early 80's, the diabetes community began efforts to develop "National Standards for Diabetes Education." This effort received its primary support through the now-defunct National Diabetes Advisory Board. In 1986, the ADA launched its "Education Recognition Program." Over the next 1 to 2 years, the ADA began development of clinical practice recommendations, and in 1988, it released the first standards of medical care for persons with diabetes.

In 1993, the Association convened a task force to determine whether diabetes quality care could be assessed in a doctor's office. The task force decided that such an assessment was possible, by reviewing medical records from physicians' offices to determine adherence to the standards of care. The task force also recommended that the ADA establish a program to recognize professionals who were meeting the medical standards.

The issue of assessing delivery of care within a practice was revisited in 1995, when the Association distilled the somewhat lengthy, narrative standards into a list of approximately 150 action items. The 150 bulleted items were distilled further into 12 measures, and ADA evaluated the measures by conducting a study at 29 difference practice sites around the country. An evaluation of the study data resulted in a total of 11 measures being adopted as part of a newly implemented "Provider Recognition Program." As Dr. Kahn noted, there is considerable overlap between the original 11 ADA measures and the current DQIP measures. The original 11 ADA measures (annual unless noted otherwise, depending on patient-specific criteria) include Hb1Ac (proportion of patients at <8 percent or > 9.5 percent), eye exam within the past year, annual foot exam, blood pressure (proportion < 140/90), nephropathy assessment within the past year, lipid profile (proportion with LDL <130 mg/dL) within the past year, tobacco status and counseling, self-management education, medical nutrition therapy, self-monitoring of blood glucose, and patient satisfaction. The first seven of these measures were similar to the current Diabetes Quality Improvement Project measures. All measures are weighted, for a total possible maximum score of 110 points; a score of 82 or better is needed to achieve ADA recognition. Recently, however, ADA modified its measure to be entirely consistent with DQIP's measures.

The ADA's Provider Recognition Program (PRP) was launched in February 1997. Approximately 1,400 doctors at 200 sites across the country have been recognized by ADA; about 35 percent of the physicians are generalists, and 65 percent are specialists. An additional 2,000 plus practices have requested applications for the PRP. The program is voluntary and offers no financial incentives to participate or achieve recognition. The future goal of the PRP is to provide a "carrot" for provider QI. Dr. Fleming stated that HCFA will be assessing thousands of practices based on HEDIS and DQIP measures; the PRP is an advantage for those who follow measures. HCFA is also looking to develop a reward or incentive program through Medicare. Dr. Kahn estimates that some 5,000–10,000 physicians across the country could qualify for PRP.

DQIP and the Private Sector (Part 2)

Dorothy Tucker, MBA, MSW, MA, Senior Health Care Analyst, NCQA, reported on NCQA's accountability program regarding DQIP measures. As Dr. Fleming noted, NCQA has played, and continues to play, an important role in encouraging private health care vendors and providers to implement DQIP measures and to establish an accountability system using these measures to improve patient care. NCQA—a partnership of managed care plans, public health professionals, patient advocates, and others—also monitors and tracks improvements and problems within the health care system. The Committee is part of the Performance Measurement Coordinating Council, which is involved in collaborative efforts to reconcile clinical guidelines and recommendations. This Council includes NCQA, the Joint Commission on Accreditation of Healthcare Organizations, and the American Medical Accreditation Program and started out in the area of diabetes on the strength of DQIP. Application of DQIP in practice, in health plans, and in the acute care setting are among the Council's goals for guiding and improving diabetes care.

NCQA's two core products include accreditation, defined as an assessment of the core systems within managed care plans on which high-quality care and services depend, and HEDIS, through

which NCQA uses six of the eight DQIP measures to assess actual results achieved by health plans. Accreditation includes onsite reviews and surveys of health plans based on specific criteria and expectations around standards, infrastructure, processes, and systems. Through recent initiatives and the addition of new measures, NCQA can now assign plans with commendable and excellent accreditation. Accountability, as measured, for example, through public health statistics and comparisons across health care plans, is the key foundation of NCQA's activities in its interactions with private health care providers. NCQA has found wide variations in performance and measures, often on a regional basis. The Committee currently is focusing on understanding the factors driving these differences (e.g., provider education, standard practice, socioeconomic issues) and identifying and developing policies that address and would reconcile such disparities.

NCQA's accreditation and accountability are integrated with HEDIS measures and statistics. Ms. Tucker pointed out the NCQA currently is the only accrediting body that incorporates performance measures and plan performance as part of the accreditation. Before implementation of the comprehensive DQIP measures, NCQA included eye examinations for diabetics, among other measures not specific to diabetes care (e.g., breast/cervical cancer screening, childhood immunization), in its accreditation process.

Ms. Tucker explained that assessment of HEDIS is a continual process in that NCQA and others examine and re-examine HEDIS data to determine the feasibility and ease in obtaining data, assess a plan's past and current performance, and identify changes in clinical practice and, where possible, patient outcome. Ms. Tucker noted that HEDIS improves accountability and makes accountability more efficient, allows health plans to track performance over time, is informative regarding health care contracting, and helps purchasers work with plans with a focus on internal QI efforts.

NCQA's scoring for accreditation includes three main factors: clinical performance (i.e., effectiveness of care/HEDIS measures) plus results of member satisfaction surveys (i.e., the "CAP" survey) account for 25 percent of the final score, and the health plan system accounts for the remaining 75 percent. Ms. Tucker noted that the contribution of the clinical care/patient satisfaction component is expected to increase in the future.

In addition to clinical evidence, feasibility studies, and data collection, NCQA conducts field tests of several health plans over a period of 12 to 18 months to assess how well specific measures actually perform. NCQA also has produced a first-year reporting measure, which serves as a beta-test of six of the DQIP measures; in brief, a measure is released in one year, and the comprehensive diabetes care assessment is conducted as data are collected and analyzed in the following years. Using these data, NCQA then revisits and revises its own testing, outreach, and evaluation efforts. The Committee's first-year reporting measures for six DQIP were released in 1999; reporting to this point in time has been largely voluntary, Ms. Tucker pointed out.

NCQA's *State of Managed Care Quality Report* indicates that health plans that report measures publicly, that are accredited, and that report over a period of time (e.g., 3 years or more)

consistently outperform plans that do not meet these specifications. These data suggest that accountability does influence outcome and performance.

For more information about NCQA, interested parties can access the Committee's Website (www.ncqa.org) or contact its Customer Support Line (1-202-955-5697), Accreditation Status Line (1-888-275-7585), or Publications Center Line (1-800-839-6487). Ms. Tucker can be contacted directly via e-mail at <tucker@ncqa.org>.

DQIP and the Public Sector

DoD

Frances Stewart, MD, CAPT, MC, USN, Program Director, Patient Advocacy and Medical Ethics, Office of the Assistant Secretary of Defense, Health Affairs, summarized how DQIP is being utilized within DoD. One of the key components in the delivery of diabetes care by DoD is the clinical practice guidelines for primary care providers, developed in collaboration with DVA. The final draft of the diabetes guidelines was released in December 1999. Guidelines for diseases that are comorbid with diabetes, such as hyperlipidemia, tobacco use, and hypertension, have been published or are nearing completion.

Each guideline includes evidence-based metrics, and medical treatment facilities are accountable for their results on the metrics that are included in the guidelines. Dr. Stewart noted that DQIP measures serve as the metrics in the joint DoD-DVA guidelines for diabetes.

Dr. Stewart explained that medical informatics is a rapidly changing area within DoD; further, information systems are not consistent across DoD and may not be for several years. Thus, implementing the new metrics in a changing environment is a challenge for the Department, which seeks to provide timely feedback regarding new metrics to its providers and providers. The Department is moving to place all patient records on one computer system, the CHCS II; pilot testing of this system began in February 2000. The agency expects implementation of this system will improve many features of delivery of care, including provider feedback and tracking patient care and testing.

DoD has developed a Diabetes Toolkit to improve the quality of patient care. A prototype informatics/database system was developed that would allow for metrics to be included in the doctor's progress notes, patient report cards and progress, interpretation of results, and advice for improvement. DQIP would be incorporated into this system.

DoD anticipates that the entire informatics structure, with DQIP as a component of that system, will improve performance through the process of measurement and track improvement in patient care.

DVA/Veterans Health Administration

Leonard Pogach, MD, MBA, National Program Director, Diabetes, DVA, reported on use of the DQIP measures in the Veterans Health Administration. He reported on the following major areas: how DVA currently uses DQIP measures, how DVA plans to use DQIP measures, and opportunities envisioned for the Federal sector. Since FY97, the measures have been used to

track performance in each of the DVA's 22 networks. Network directors are held accountable for results of all clinical performance measures in their performance contracts. Data are collected quarterly through independent external peer review. Other data, to evaluate demographic factors and assess QI, are automatically collected and then published in electronic reports. DVA also has incorporated the measures in the Diabetes Quality Enhancement Research Initiative, funded in FY99.

DVA plans to use DQIP measures to evaluate demographic factors and racial disparities and to influence major national translational programs of research into practice. DVA also plans to continue to use the measures in its research efforts (FY00–FY02). Efforts include cross-validation of chart audits, electronic data, and surveys; additional validation of the DQIP Survey in the veteran population; longitudinal analysis of DQIP data; provider profiling; and case mix adjustment models.

Dr. Pogach reported that for the Federal sector DVA envisions a leadership role in improving clinical care through benchmarking of data, sharing of successful practices, and continuing its commitment to DQIP; advancing DQIP through collaborative efforts to pilot test new measures; implementing internal and external research initiatives; and making a correlation between DQIP and outcomes in longer term longitudinal analyses.

DVA sees potential for data sharing through MOAs, collaborative QI multiagency demonstration projects, and shared research initiatives.

Dr. Pogach pointed out that using, collecting, and tracking DQIP measures have led to improvements in all DQIP domains among VHA diabetic patients, except for blood pressure.

IHS

Kelly Acton, MD, MPH, Director, IHS National Diabetes Program, opened her presentation by noting that IHS has been measuring quality indicators of diabetes care through its annual Diabetes Care and Outcome Audit since 1986. Most of the 87 measures have been tracked since 1992, and all have been included in the audit since 1994.

Some of the results of record audits conducted between 1992 and 1998 are presented here.

- As the prevalence of diabetes has increased, the number of records audited has increased, from approximately 7,000 in 1992 to 11,518 in 1998.
- Between 20 and 27 percent of diabetic persons diagnosed with hypertension have their blood pressure under control.
- Glycemic control, measured by HbA1c, varies by age. HbA1c levels are consistently higher among younger persons; however, a downward trend in this measure over time has been reported for all age groups. Approximately 25 percent of the diabetic population have good control (< 7.5 percent). Previously, reports simply indicated good, fair, or poor glycemic control. Starting this year, detailed results will be published and presented to providers.
- Eighty percent or more of diabetic patients are tested for proteinuria annually.

- Eye exam rates have stayed consistently at 53 to 55 percent during the several years, despite a variety of interventions.

The findings of the annual audits are being benchmarked against DQIP measures to reinforce and validate the recommendations of the IHS National Diabetes Program to perform the 87 elements and to compare and validate regional differences and national data.

HCFA

In adding to her earlier presentation, Dr. Fleming noted that HCFA is focused on the areas of measurement and improvement and is also in the process of developing a rewards and incentives package. HCFA continues to work on DQIP-based QI with the plans and PROs in all 50 states. Under one scenario, a plan is directed to develop a QI program using one DQIP measure; the plan must then show significant improvement in that measure over a 3-year period to retain its contract with HCFA. PROs are directed to track three DQIP measures among their beneficiaries, with retention of the contract tied to the QI of the measures. Comments and suggestions on DQIP activities at HCFA should be forwarded to Dr. Fleming via e-mail (bfleming@hcfa.gov) or phone (1-410-786-6863).

Dr. Stewart then asked that attendees representing other government agencies step forward and present a summary of the status or relevance of DQIP within their organizations.

CDC

Michael Engelgau, MD, MS, Division of Diabetes Translation, CDC, stated that the CDC is interested in diabetes and DQIP for several reasons, and that CDC was involved in the early versions of HEDIS as well as in DQIP 1.0 and now DQIP 2.0 and assisted the measures subcommittee in the development of eye, foot, glycemic control (HbA1c), and kidney quality indicators and DQIP measurement sets by providing a public health perspective.

CDC has been tracking self-care, education, and eye exam measures on a state-by-state basis since 1994 through its Behavioral Risk Factor Surveillance System (BRFSS).

Other CDC-related activities or collaborations include the Diabetes Control Programs, the development of model contract language that Medicaid programs can use in negotiating with managed care companies for plans to include diabetes programs, the Association of States and Territorial Chronic Disease Program Directors, the National Diabetes Education Program, and partnerships with several non-government organizations to promote diabetes awareness and QI.

In the future, the CDC, in collaboration with NIDDK and DVA, will be focusing on TRIAD (Translating Research Into Action for Diabetes), a multicenter project initiated approximately 1 year ago. This project will include at least 10 health plans, 40 provider groups, and 15,000 patients with diabetes. Findings from TRIAD are likely to contribute to the future development of DQIP.

QuIC

Dr. Stewart explained that, thus far, QuIC has focused primarily on disseminating the current DQIP-related information and bringing new partners to the table (e.g., ADA, DVA, HCFA, DoD). Funding for QuIC efforts is very limited. QuIC's five working groups—Consumer and Patient Information, Key Opportunities for Clinical Quality Improvement, Measures, Developing the Workforce, and Information Systems—meet on an as-needed basis. The Steering Committee meets every 6 weeks. Dr. Stewart noted that the QI working group has been charged with three task areas: clinical guidelines (in the areas of diabetes, depression, and substance abuse), patient safety, and formulary issues. Once clinical guidelines are approved, they will be available to the public. QuIC meetings are open but limited to Federal employees and partners; however, the group welcomes input and feedback from the private sector.

NIH

Philip Sheridan, MD, Program Director, Developmental Neurobiology Program, NIDDK, commented briefly on NIH's role in advancing and improving health care. In just 15 years, QI and delivery of care has moved beyond the bench-to-bedside paradigm and now includes benchmarking, implementing results of clinical trials, and increasing emphasis on clinical research training. Recent years also have seen increased interactions and collaborations among agencies regarding overall research planning and setting of strategic goals, participation in consensus conferences, and development of strategic and long-range plans with input from patient advocacy and professional organizations. The importance of multidisciplinary and multiorganizational collaborations underscores these efforts.

Dr. Sheridan continued by noting that NIH has become a more active player in the QI "movement" with departmental and Presidential initiatives on quality in place. NIH has been approached by the National Center for Health Statistics and AHRQ to solicit assistance in developing data for a report on the national quality of health care, which is due to the President in 2002.

Afternoon Session: Brainstorming

Roland Hiss, MD, Chair, Department of Medical Education, and Director, Demonstration and Education Division, Michigan Diabetes Research and Training Center, University of Michigan Medical School, facilitated this brainstorming session, during which attendees were asked to suggest issues that should be considered further with respect to DQIP collaborations. The following list includes those suggestions.

1. Benchmarking.
2. Symposium on "Profiling" planned for June 2000, sponsored by Federal agencies with an interest in diabetes and to occur in association with the annual convention of the ADA.
3. State-level (Diabetes Control Program) collaboration with the PROs.
4. The CDC publication *Diabetes Surveillance*, last published in 1997, is available at http://www.cdc.gov/diabetes/survl/surveill.htm. The results of the BRFSS, which assesses preventive care practices, are published periodically in *MMWR*. This will probably also be the case for TRIAD.

5. Ongoing DCCT followup, which includes the DQIP measures.
6. Translational research on DQIP implementation.
7. DQIP use within Federal agencies to highlight successes and problems.
8. Data sets from agencies who have them made available for study.
9. CDC publication of state and regional data.
10. Continuous sharing of DQIP data between Federal agencies. (The subsequent discussion suggested that this be accomplished by periodic additions to the DMICC Webpage.)
11. Each agency should prepare its own "report card."
12. DQIP Operating Committee continually look at the experience of DQIP implementation and change or add to the DQIP measures as indicated.
13. DMICC Website posting of Federal agency DQIP data.
14. QuIC continuous analyses of DQIP data.
15. NCHS develop a QI model and include it in national surveys such as NHANES III or IV.
16. This number was inadvertently skipped over by the facilitator (i.e., no item/activity is assigned to this number).
17. Commonly shared purposes:
    a. Documenting racial disparities
    b. Common tools for database collection (demographics, minorities, etc.). Responsibility for conducting this activity was initially assigned to the QuIC, but subsequent discussion, noted below, assigned this to a public/private sector collaboration.
    c. Reward systems that provide good care.
18. Continue to hold "best practices" conferences about every 18 months.
19. Annual submission of "best practices" to the combination of HCFA, ADA, and AAFP (as was done in association with the Millennium Conference of August 1999), with HCFA taking the lead.
20. Increase the role of other Federal agencies in the research agenda beyond the "usual suspects."
21. Benchmark the U.S. population through NHANES III.
22. DQIP update at each DMICC meeting and integrate DQIP activities into whatever the main topic for discussion is at each meeting.

Summary and Next Steps

Recommendations and Their Implementation

First-Tier (Top) Activities

The meeting attendees were asked to place a checkmark (vote) next to four items from the discussion list that they thought were the most important. The list below contains the items that received either four or five votes and notes the subsequent discussion at the summary session concerning responsibility for followup or implementation of these activities.

1. *DCCT followup* (former #5). This has been under way for some time and will continue. It is an activity of the NIDDK.
2. *DMICC Website, for posting of DQIP data from Federal agencies* (former #13). The DMICC is organized and directed by the NIDDK, and that agency will establish DQIP data on its Website http://www.niddk.nih.gov/federal/dmicc.htm.

3. *Common database tools* (former #17b). This was thought to be the most important "next step" activity, as currently each agency has its own rules and format for its database, and a common merging of DQIP data, or data from any other categorical diseases, would be problematic without a common understanding of definitions, scope, format, and other relevant information. During the discussion, a public/private sector collaboration was established that would involve the DMICC, QuIC and the ADA, with the ADA taking the lead responsibility.
4. *Benchmark the U.S. population during NHANES III and beyond* (former #21). Responsibility for NHANES rests with the NIDDK, CDC, and CHS.

Second-Tier Activities

The following activities received three votes from meeting participants.

1. *Translational research concerning DQIP issues* (former #6). Discussion of this item bogged down with confusion over definition as to whether this meant establishing a research agenda or funding and conducting such research. Resolution of this question was postponed to the next DMICC meeting, where it will be placed on the agenda.
2. *DQIP Operating Committee followup* (former #12). This activity is already being done with recommendations made to the QUIC.
3. *DQIP update at each DMICC meeting and also at each QuIC meeting* (former #22). Minutes of these meetings will be posted on the DMICC Website for the benefit of all interested parties.
4. *Documenting racial disparities* (former #17a). The NIDDK indicated that data concerning hemoglobin A1c and blood pressure would be obtained through future NHANES activities. The definition of minority status and agreement on how to report racial disparity information was assigned to the "database" project to be undertaken by the public/private sector collaboration (see above).

A ranking of pertinent barriers and opportunities facing DQIP collaborations can be found below.

Next Steps

In sum, attendees agreed that the basic overarching, guiding principle for implementing these strategies and recommendations is a basic commitment across the health care system to use DQIP measures for the assessment of diabetes care.

It was suggested that progress reports on DQIP top priorities be presented at a future DMICC meeting; data and progress reports also might be placed on the DMICC Website, possibly in spreadsheet format. Attendees also requested that DMICC-related progress reports be presented to the QuIC Executive Committee.

Issues Concerning DQIP Collaborations

Ranking value of 1 = 3 points, 2 = 2 points, 3 = 1 point

Points	BARRIERS	Points	OPPORTUNITIES
12	Insufficient staff and related resources Ranking: 1+1+1+1	**3**	To learn of the successes/problems other agencies are experiencing Ranking: 1
4	Lack of single easily accessible database Ranking: 3+2+3	**17**	To promote better diabetes care within agency and the country Ranking: 1+1+1+1+1+2
2	Concerns about value/validity of DQIP Ranking: 2	**5**	To define and quantify racial disparities Ranking: 1+2
5	Variable support/interest within agency Ranking: 2+2+3	**3**	To map geographic variation Ranking: 3+2
	Diabetes not a high priority within agency	**1**	To collaborate on DQIP-related projects Ranking: 3
2	Tradition of agency independence Ranking: 3+3	**1**	To demonstrate agency commitment to diabetes Ranking: 3
	Waiting for rest of package before implementing	**1**	To acknowledge/reward exemplary care within agency Ranking: 3
	Concerns re "report card" effect	**3**	To identify need for improvements within agency Ranking: 2+3
4	Lack of communication mechanism between agencies Ranking: 2+2	**5**	To work collaboratively with other federal agencies Ranking: 3+2+2
	Lack of communication within agency		To work collaboratively with private health plans
3	Write in: Sustainable effort Ranking: 1	**2**	Write in: Develop methods Ranking: 2
1	Write in: "Quality improvement" not traditionally within NIH mission. NIH does not deliver health care Ranking: 3	**1**	Write in: Develop information system Ranking: 3
		2	Write in: To understand basis of low quality, develop interaction strategy Ranking: 2
		1	Write in: Prioritize a research agenda for quality improvement Ranking: 3

Approved by: _____ Date: _____

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